Reimbursement

This unit must operate as a distinct part unit from the rest of the nursing facility. Reimbursement levels will be established effective July 1, using an interim payment rate that will be subject to final settlement upon the submission of a cost report of at least six months of operation. Upon submission of a final cost report all costs must meet the allocability criteria and reasonableness established in ARM 37.40.345, 346 and 347.

Settlement of costs will be within a lower limit and an upper limit established as follows:

If the unit provides the required services for less than the interim rate times 95 percent, the lower limit, the facility will be allowed to maintain all amounts between the lower limit and the actual settled cost per day for provision of the services through the settlement process.

If the unit provides the required services for an allowable cost per day between the interim rate times 95 percent and the interim rate time 105 percent the facility will receive their actual allowable cost per day through the settlement process.

If the unit provides the required services for an allowable cost per day in excess of the interim rate times 105 percent, the upper limit, they will receive 100 percent of their cost up to the upper limit through settlement and any allowable costs in excess of the upper limit will be settled at 75 percent of the incurred costs through the settlement process.

Maximum occupancy in the unit will be 19 residents. The facility will be required to maintain a 90 percent occupancy for reimbursement purposes in this unit. If the unit operates at less than 90 percent an assumed 90 percent occupancy will be utilized in the final rate settlement process for this facility.

37.40.331 ITEMS BILLABLE TO RESIDENTS (1) The department will not pay a provider for any of the following items or services provided by a nursing facility to a resident. The provider may charge these items or services to the nursing facility resident:

(a) gifts purchased by residents;

(b) social events and entertainment outside the scope of the provider's activities program;

(c) cosmetics and grooming items and services in excess of those for which payment is made by medicare or medicaid;

(d) personal comfort items, including tobacco products and accessories, notions, novelties, and confections;

(e) personal dry cleaning;
(f) beauty shop services;
(g) television, radio and private telephone rental;
(h) less-than-effective drugs (exclusive of stock items);
(i) vitamins, multivitamins, vitamin supplements and calcium supplements;
(j) personal reading materials;
(k) personal clothing;
(l) flowers and plants;
(m) privately hired nurses or aides;
(n) specially prepared or alternative food requested instead of food generally prepared by facility; and
(o) the difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers);

(2) Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(a) A provider must provide a medically necessary private room at no additional charge and may not bill the recipient any additional charge for the medically necessary private room.

(b) A provider may bill a resident for the extra cost of a private room if the private room is not medically necessary and is requested by the resident. The provider must clearly inform the resident that additional payment is strictly voluntary. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 10/1/93; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 32 through 35 reserved

37.40.336 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (1) For intermediate care facility services for the mentally retarded provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with ARM 37.40.345 and 37.40.346, divided by the total patient days of service during the rate year, minus the amount of the medicaid recipient's patient contribution, subject to the limits specified in (2)(a) and (b).

(2) Payments under (1) may not exceed the following limits:

(a) Final per diem payment rates for base years shall be as specified in (1), without application of any further limit. Base years are even-numbered state fiscal years, i.e., state fiscal years 1994, 1996 and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

(3) All ICF/MR providers must use a July 1 through June 30 fiscal year for accounting and cost reporting purposes.

(4) Prior to the billing of July services each rate year, the department will determine an interim payment rate for each provider. The provider's interim payment rate shall be determined based upon the department's estimate of actual allowable cost under ARM 37.40.345, divided by estimated patient days for the rate year. The department may consider, but shall not be bound by, the provider's cost estimates in estimating actual allowable costs. The provider's interim payment rate is an estimate only and shall not bind the department in any way in the final rate determination under (1) and (5).

(5) The provider's final rate as provided in (1) shall be determined based upon the provider's cost report for the rate year filed in accordance with ARM 37.40.346, after desk review or audit by the department's audit staff. The difference between actual includable cost allocable to services to medicaid residents, as limited in (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in ARM 37.40.347.

(6) Following the sale of an intermediate care facility for the mentally retarded after April 5, 1989, the new provider's property costs will be the lesser of historical costs or the rate used for all other intermediate care facilities, subject to the limitations in 42 USC 1396a(a)(13)(C). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.337 REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana medicaid individuals at the medicaid rate and upon the basis established by the medicaid agency in the state in which the facility is located.

(2) The Montana medicaid program will pay for nursing facility services or related supplies provided to eligible Montana medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, Consultec, at P.O. Box 4286, Helena, MT 59604-4286, Helena, MT 59604-4286.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state medicaid agency establishing or stating the facility's medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state medicaid agency establishing or stating the medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by ARM 37.40.201, et seq.;

(i) To the extent required by ARM 37.40.201, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for medicaid during the period services were provided; and

(h) assurances that, during the period the billed services were provided, the facility was not operating under sanctions imposed by medicare or medicaid which would preclude payment.

(5) Reimbursement to nursing facilities located outside the state of Montana for medicare coinsurance days for dually eligible medicaid and medicare individuals shall be limited to the per diem rate established by the facility's state medicaid agency, less the medicaid recipient's patient contribution. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

37.40.338 BED HOLD PAYMENTS (1) Except as provided in (6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident for whom the bed is held is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return to the provider;

(c) the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available; and

(d) the provider has received written approval from the department's senior and long term care division as provided in (4).

(2) For purposes of (1), a provider will be considered full if:

(a) all medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) as to gender, if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients.

(3) For purposes of (1), the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of the anticipated duration of the absence. Temporary absences which are of indefinite duration must be documented at least weekly by the provider to assure that the absence is indeed temporary.

(4) A provider's request for the department's written approval of bed hold days as required in (1) must be submitted to the department's senior and long term care division on the form provided by the department within 90 days after the first day of the requested bed hold

period. The request must include a copy of the waiting list applicable to each bed hold day claimed for reimbursement.

(5) Where the conditions of (1) through (4) are met, providers are required to hold a bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department's senior and long term care division. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill medicaid for the bed hold day until all conditions of billing are met and may not bill the resident under any circumstances.

(6) Payment will be made to a provider for holding a bed for a resident during a therapeutic home visit only if:

(a) the recipient's plan of care provides for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit; and

(c) the resident is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence. If a resident leaves the facility unexpectedly, on a weekend or a non business day for a visit longer than 72 hours, a provider must call in to the department on the next business day to receive prior authorization for the visit. If a resident is unexpectedly delayed while out on a therapeutic home visit, a provider must call the department and receive prior authorization if that delay will result in the visit exceeding 72 hours or obtain an extension for a visit that was previously approved by the department in excess of 72 hours.

(7) The department may allow therapeutic home visits for trial placement in the home and community services (medicaid waiver) program.

(8) No more than 24 days per resident in each rate year (July 1 through June 30) will be allowed for therapeutic home visits.

(9) The provider must submit to the department's senior and long term care division a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the department's senior and long term care division.

(10) Approvals or authorizations of bed hold days obtained from county offices will not be valid or effective for purposes of this rule. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.339 MEDICARE HOSPICE BENEFIT - REIMBURSEMENT

(1) In accordance with section 9435(b) of the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509, the department may not pay a nursing facility provider for services provided to an eligible medicaid/medicare individual who has elected the medicare hospice benefit.

(a) This rule applies where the hospice provider and the nursing facility provider have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual.

(b) When this rule applies, the department will pay the hospice provider in accordance with the department's rules governing medicaid reimbursement to hospice providers. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

Rules 40 through 44 reserved

37.40.345 ALLOWABLE COSTS (1) This rule applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for allowable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the health insurance manual 15 (HIM-15), published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the HIM-15 may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. Applicability of the HIM-15 is subject to the exceptions and limitations specified in this rule.

(a) The term "allowable costs" means costs which are allowable under the provisions of this subchapter and which are considered in determining the costs of providing medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in ARM 37.40.346, allowable costs will be determined in accordance with the HIM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for the mentally retarded which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers from established lending institutions at the date of asset acquisition or at the inception of the lease.

(iii) Leases must be capitalized according to generally accepted accounting principles.

(iv) Depreciation of real property and movable equipment must be in accordance with American hospital association guidelines. Depreciation of real property and movable equipment based upon accelerated cost recovery guidelines is not an allowable cost.

(v) In accordance with sections 1861(v)(1)(O) and 1902(a)(13) of the Social Security Act, allowable property costs shall not be increased on the basis of a change in ownership which takes place on or after July 18, 1984. Section 1861(v)(1)(O) and section 1902(a)(13) of the Social Security Act are hereby adopted and incorporated herein by reference. The cited statutes are federal statutes governing allowability of certain facility property costs for purposes of medicare and medicaid program reimbursement. Copies of these sections may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 N. Sanders, Helena, MT 59604-4210.

(c) Administrator compensation is allowable only as determined according to the HIM-15 provisions relating to owner compensation, and as specifically limited in this rule.

(i) For purposes of reporting and determining allowable administrator compensation, administrator compensation includes:

(A) all salary paid to the administrator for managerial, administrative, professional or other services;

(B) all employee benefits except employer contributions required by state or federal law for FICA, workers' compensation insurance (WCI), federal unemployment insurance (FUI), and state unemployment insurance (SUI);

(C) all deferred compensation either accrued or paid;

(D) the value of all supplies, services, special merchandise, and other valuable items paid or provided for the personal use or benefit of the administrator;

(E) wages of any provider employee to the extent such employee works in the home of the administrator;

(F) the value of use of an automobile owned by the provider business to the extent used by the administrator for uses not related to patient care;

(G) personal life, health, or disability insurance premiums paid by the provider on the administrator's behalf;

(H) the rental value of any portion of the facility occupied by the administrator as a personal residence;

(I) the value of any other remuneration, compensation, fringe or other benefits whether paid, accrued, or contingent.

(d) Allowable costs include employee benefits as follows:

(i) Employee benefits are defined as amounts accrued on behalf of an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death, if uniformly applicable to all employees. An item is an employee benefit only if it directly benefits an indvidual employee and does not directly benefit the owner, provider or related parties.

(ii) Employee benefits include all employer contributions which are required by state or federal law, including FICA, WCI, FUI, SUI.

(iii) Costs of recreational activities or facilities available to employees as a group, including but not limited to condominiums, swimming pools, weight rooms and gymnasiums, are not allowable.

(iv) For purposes of this rule, an employee is one from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, and sole proprietors and partners owning or operating a facility are not employees even if FICA is withheld for them.

(v) Accrued vacation and sick leave are employee benefits if the facility has in effect a written policy uniformly applicable to all employees within a given class of employees, and are allowable to the extent they are reasonable in amount.

(e) Bad debts, charitable contributions and courtesy allowances are deductions from revenue and are not allowable costs.

(f) Revenues received for services or items provided to employees and guests are recoveries of cost and must be deducted from the allowable cost of the related items.

(g) Dues, membership fees and subscriptions to organizations unrelated to the provider's provision of nursing facility services are not allowable costs.

(h) Charges for services of a chaplain are not an allowable cost.

(i) Subject to (4), fees for management or professional services (e.g., management, legal, accounting or consulting services) are allowable to the extent they are identified to specific services and the hourly rate charged is reasonable in amount. In lieu of compensation on the basis of an hourly rate, allowable costs may include compensation for professional services on the basis of a reasonable retainer

agreement which specifies in detail the services to be performed. Documentation that such services were in fact performed must be maintained by the provider. If the provider elects compensation under a retainer agreement, allowable costs for services specified under the agreement are limited to the agreed retainer fee.

(j) Travel costs and vehicle operating expenses related to resident care are allowable to the extent such costs are reasonable and adequately documented.

(i) Vehicle operating costs will be allocated between business and personal use based on actual mileage logs, a percentage derived from a sample mileage log and pre-approved by the department, or any other method pre-approved by the department.

(ii) For vehicles used primarily by an administrator, any portion of vehicle costs allocated to personal use shall be included as administrator compensation and subject to the limits specified in (3)(c).

(iii) Allowable costs include automobile depreciation calculated on a straight-line basis, subject to salvage value, with a minimum of a 3-year useful life. The total of automobile depreciation and interest, or comparable lease costs will not be allowable in excess of $7,500 per year.

(iv) Public transportation costs will be allowable only at tourist or other available commercial rate (not first class).

(k) Allowable costs for purchases, leases or other transactions between related parties are subject to the following limitation:

(i) Allowable cost of services, facilities and supplies furnished to a provider by a related party or parties shall not exceed the lower of costs to the related party or the price of comparable services, facilities or supplies obtained from an unrelated party. A provider must identify such related parties and costs in the annual cost report.

(4) Costs, including attorney's fees, in connection with court or administrative proceedings are allowable only to the extent that the provider prevails in the proceeding. Where such proceedings are related to specific reimbursement amounts, the proportion of costs which are allowable shall be the percentage of costs incurred which equals the percentage derived by dividing the total cost or reimbursement on which the provider prevails by the total cost or reimbursement at issue. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.346 COST REPORTING, DESK REVIEW AND AUDIT

(1) Providers must use generally accepted accounting principles to record and report costs. The provider must, in preparing the cost

report required under this rule, adjust such costs in accordance with ARM 37.40.345 to determine allowable costs.

(2) Providers must use the accrual method of accounting, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(3) Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain the provider's costs of the various services provided. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 (1997), which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. Notwithstanding the above, distinctions between skilled nursing and nursing facility care need not be made in cost finding.

(4) All providers must report allowable costs based upon the provider's fiscal year and using the financial and statistical report forms designated and/or provided by the department. Reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) A provider must file its cost report:

(i) within 90 days after the end of its designated fiscal year;

(ii) within 90 days after the effective date of a change in provider as defined in ARM 37.40.325; or

(iii) for changes in providers occurring on or after July 1, 1993, within 90 days after 6 months participation in the medicaid program for providers with an interim rate established under ARM 37.40.326. Subsequent cost reports are to be filed in accordance with (4)(a)(i) above and subsequent cost reports shall not duplicate previous cost reporting periods.

(b) The report forms required by the department include certain medicare cost report forms and related instructions, including but not limited to certain portions of the most recent version of the HCFA-2540 or HCFA-2552 cost report forms, as more specifically identified in the department's cost report instructions. The department also requires providers to complete and submit certain medicaid forms, including but not limited to the most recent version of the medicaid expense statement, form DPHHS-MA-008A.

(i) In preparing worksheet A on the HCFA-2540 or HCFA-2552 cost report form, providers must report costs in the worksheet A category that corresponds to the category in which the cost is reportable on the medicaid expense statement, as designated in the department's cost report instructions.

(ii) For purposes of the medicaid cost report required under this rule, all medicare and medicaid cost report forms must be prepared in

accordance with applicable cost report instructions. Medicare cost report instructions shall apply to medicare cost report forms to the extent consistent with medicaid requirements, but the medicaid requirements specified in these rules and the department's medicaid cost reporting instructions shall control in the event of a conflict with medicare instructions.

(c) If a provider files an incomplete cost report or reported costs are inconsistent, the department may return the cost report to the facility for completion or correction, and may withhold payment as provided in (4)(d).

(d) If a provider does not file its cost report within 90 days of the end of its fiscal year, or if a provider files an incomplete cost report, the department may withhold from payment to the provider an amount equal to 10% of the provider's total reimbursement for the month following the due date of the report or the filing of the incomplete report. If the report is overdue or incomplete a second month, the department may withhold 20% of the provider's total reimbursement for the following month. For each succeeding month for which the report is overdue or incomplete, the department may withhold the provider's entire medicaid payment for the following month. If the provider fails to file a complete and accurate cost report within 6 months after the due date, the department may recover all amounts paid to the provider by the department for the fiscal period covered by the cost report. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(e) The department may grant a provider one 30-day extension for filing the cost report if the provider's written request for the extension is received by the department prior to expiration of the filing deadline and if, based upon the explanation in the request, the department determines that the delay is unavoidable.

(f) Cost reports must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports must sign, under penalties of false swearing, upon an affirmation that he has examined the report, including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared in accordance with applicable laws, regulations, rules, policies and departmental instructions.

(5) A provider must maintain records of financial and statistical information which support cost reports for 6 years, 3 months after the date a cost report is filed, the date the cost report is due, or the date upon which a disputed cost report is finally settled, whichever is later.

(a) Each provider must maintain, as a minimum, a chart of accounts, a general ledger and the following supporting ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable,